

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 2 — 0 6

2. STATE:

MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

February 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.110

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ -0-

b. FFY 2003 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 3.1-A  
pages 4, 4a, 8, 9, 19 and 27h9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):Supplement to Attachment 3.1-A  
pages 4, 4a, 8, 8, 19 and 27h

10. SUBJECT OF AMENDMENT:

Therapies

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

James K. Haveman, Jr.

14. TITLE:

Director

15. DATE SUBMITTED: 3/22/02

16. RETURN TO:

Michigan Department of Community Health  
Federal Liaison Section  
6th Floor Lewis Cass Building  
320 South Walnut Street  
Lansing, Michigan 48913

ATTENTION: Nancy Bishop

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

3/25/02

18. DATE APPROVED:

6/07/02

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

2/1/02 BAH

20. SIGNATURE OF REGIONAL OFFICIAL:

Alan Freund, acting RRA

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator  
Division of Medicaid and Children's Health

23. REMARKS:

MAR 25 2002

DMCH - M

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State: MICHIGAN**

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE  
SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY**

General nursing service incidental to the care and treatment of the patient.

Whole blood (when not available from other sources).

Other items and services ordinarily provided by the hospital for the care and treatment of inpatients.

The use of all prosthetic and surgical appliances and any other equipment essential to the treatment of the patient.

Physical therapy services must be either restorative or specialized maintenance programs to be covered. Physical therapy must be ordered by a physician in writing. Therapy services must be provided by a physician, a physical therapist currently licensed in Michigan, or physical therapy assistant under the appropriate supervision of an appropriately licensed physical therapist. A treatment plan must be developed, identifying the individual modalities to be employed and how they relate to the condition being treated. Each restorative plan must include the expected results of the therapy and the time frames needed to achieve those results.

Inpatient occupational therapy services of a restorative nature, ordered in writing by a physician, are covered. Therapy services must be performed by an occupational therapist currently registered in Michigan, an appropriately supervised certified occupational therapy assistant, or an appropriately supervised student completing his/her clinical affiliation.

Inpatient psychiatric occupational/recreational therapy is covered when ordered in writing by a physician as part of the beneficiary's active psychiatric treatment plan. It must be provided by a psychiatrist, an occupational therapist currently registered in Michigan, an appropriately supervised certified occupational therapy assistant, or an appropriately supervised student completing his/her clinical affiliation, in a psychiatric hospital or a psychiatric unit of a general hospital.

TN NO. 02-06

Approval Date \_\_\_\_\_

Effective Date 02-01-02

Supersedes

TN No. 94-25

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State: MICHIGAN**

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE  
SERVICES PROVIDED TO THE CATEGORIALY AND MEDICALLY NEEDY**

Speech-language therapy services must be restorative and ordered in writing by a physician to be covered. Services must be rendered by a speech-language pathologist possessing a current Certificate of Clinical Competence or Letter of Equivalency from the American Speech-Language Hearing Association, an appropriately supervised speech-language pathologist candidate, or an appropriately supervised student completing his/her clinical affiliation.

**Substance Abuse Services**

If a hospital has a sub acute substance unit, that unit must meet the requirements in Attachment 3.1-A, pp. 26, 26a, 13(d) 1 to receive reimbursement for the services described in that section.

If acute care detoxification is warranted, it will be covered. However, once the beneficiary's condition is stabilized, he or she must be referred to an appropriate treatment service.

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TN No. 94-25

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
State of Michigan

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE  
SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY**

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**2. OUTPATIENT HOSPITAL SERVICES**

Professional fees for services provided in the outpatient department of a hospital will be paid only when such payment does not duplicate payment to the hospital.

Educational costs associated with the outpatient department will be reimbursed to hospitals with approved training programs (as described in 404.1 of the HIM-15 manual).

Payment will not be made for services of staff in residence, e.g., interns and residents or medical staff functioning in an administrative or supervisory capacity (including physician-owners) who are paid by the hospital or other sources.

Outpatient services relating to routine examinations only, i.e., unrelated to a specific illness, symptom, complaint, or injury, are not covered, except when provided to eligible children under age 21 as part of a program of early and periodic screening, diagnosis and treatment. (See Item 4b.)

Outpatient hospital services include prenatal and postnatal care; and services listed below when medically necessary for the diagnosis or treatment of an illness or injury when ordered by and under the direction of a physician (M.D. or D.O.), and services performed by the physician:

- 1) radium treatment
- 2) therapeutic x-ray
- 3) diagnostic x-ray
- 4) emergency treatment
- 5) physical therapy, as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required if services exceed the time or frequency for:
  - initial treatment (36 times in 90 consecutive calendar days) or
  - maintenance/monitoring (four times in the 90-day allowed period)
- 6) laboratory tests

**NOTE:** Lab payments to an outpatient hospital are limited to a maximum rate per beneficiary, per hospital. This rate is determined to be adequate to cover reasonable and necessary procedures. Lab services in excess of this rate are covered on an exception basis when determined to be medically necessary by the department.

- 7) electrocardiogram
- 8) electroencephalogram
- 9) basal metabolism
- 10) hemodialysis

**NOTE:** The patient who receives hemodialysis in his home is considered to be a hospital outpatient. Therefore, payment for the cost of hemodialysis supplies, such as plastic tubing, chemicals, disposable coils, etc., may be made under the Program.

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- 11) individual and group psychotherapeutic treatment rendered by a psychiatrist or physician (M.D. or D.O.) in the outpatient department of a licensed psychiatric hospital or of a general hospital with a licensed psychiatric unit.
- 12) play therapy (for children) and family therapy rendered by a psychiatrist or physician (M.D. or D.O.) in the outpatient department of a licensed psychiatric hospital or of a general hospital with a licensed psychiatric unit.
- 13) psychological testing (may be administered by a psychologist, for diagnostic purposes, when ordered and billed for by the physician).
- 14) prescribed drugs and medications dispensed by the outpatient facility in connection with treatment received at the facility and administration of such drugs.

**NOTE:** Nonlegend drugs, with the exception of insulin, family planning drugs and supplies, and those drugs necessary for the treatment of chronic renal disease, are not covered. Certain anti-anxiety, analgesic, anorectic, cough and cold, antacid, laxative anti-vertigo, hematinic, vitamins, nutritional supplements, and other drugs specified by the department are not covered.

- 15) covered oral surgical procedures, as listed under Inpatient Hospital Services, specified in 1.a.
- 16) occupational therapy as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is the same as presented for physical therapy at 5) above.
- 17) psychiatric occupational/recreational therapy, as defined in 1.a, only in conjunction with partial hospitalization.
- 18) speech-language therapy services, as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is the same as presented for physical therapy at 5) above.

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- 4) Physical therapy, as described in 1.a of Supplement to Attachment 3.1-A when provided by a Medicaid-enrolled home health agency. Prior approval is required if services exceed the time or frequency for:
- initial treatment (24 times in 60 consecutive calendar days) or
  - maintenance/monitoring (four times in the 60-day allowed period)
- 5) Occupational therapy services, as described in 1.a of Supplement to Attachment 3.1-A, of a restorative nature, are covered when ordered in writing by a physician, and provided by a Medicaid-enrolled home health agency. Prior approval is the same as presented at 4) above.

b. Excluded services

“Non-covered care” under the Medical Assistance Program, i.e., care which is designed essentially to assist the individual in meeting the activities of daily living and does not require the additional services of trained medical or paramedical personnel.

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of Michigan

**AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE  
SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY**

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13d. 8) **Hearing and Speech Services**

Covered speech-language and audiology services, as defined in 1.a of Supplement to Attachment 3.1-A, must be provided by a speech-language pathologist or audiologist (as appropriate) possessing a current Certificate of Clinical Competence or Letter of Equivalency from the American Speech-Language Hearing Association, an appropriately supervised speech-language pathologist candidate, or an appropriately supervised student completing his/her clinical affiliation. Services must be provided under the auspices of (and be billed by) a Medicaid enrolled outpatient hospital or hearing and speech center. Prior approval is required if services exceed the time or frequency for:

- initial treatment (36 times in 90 consecutive calendar days) or
- maintenance/monitoring (four times in the 90 day allowed period).

9) **Intensive/Crisis Residential Services**

Intensive/crisis residential services are intended to provide a short-term alternative to psychiatric inpatient services. Services are intended to avert psychiatric admissions or to shorten the length of stay in a psychiatric inpatient setting. Services will be available to adults and children who meet psychiatric inpatient admission criteria, but who can be appropriately served in settings less intensive than a hospital. Intensive /crisis residential services may be provided to beneficiaries who are assessed by, and admitted through the authority of an enrolled mental health clinic (Provider Type 21).

Services will be provided under the auspices of a Medicaid-enrolled mental health clinic. Services will be provided in licensed residential settings that do not exceed 16 beds. Services will not be provided in hospitals or institutional settings. Services in the crisis residential setting will be time limited. Appropriate follow-up services will be provided by the mental health clinic, under its responsibilities as the mental health case management agency.

Medicaid covered intensive/crisis residential services include: psychiatric supervision, therapeutic support services, nursing services, medication management/stabilization and education, behavioral services and milieu therapy. Services will be provided by qualified mental health staff, under psychiatric supervision, and according to an individual plan of service.

Services may be provided for a period up to 14 calendar days per crisis residential episode and may be extended for up to 30 days per admission, if justified by clinical need as determined by the inter-disciplinary team.

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